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BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended and Supplemental Accusation Against:	No. 17-1995-57676
	OAH No. 1999020077
RAJA KAIRALLA SROUR, M.D.	
Physician's and Surgeon's Certificate No. A30278,	
Respondent.	

DECISION AND ORDER

The attached Stipulated Settlement and Decision is hereby adopted as the Decision and Order of the Division of Medical Quality, Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on July 7, 2000.

Dated June 7, 2000.

DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA

Ira Lubell, M.D., Chair
Panel A

BILL LOCKYER, Attorney General
of the State of California
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Attorneys for Complainant

BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended and Supplemental Accusation Against: **RAJA KAIRALLA SROUR, M.D.** 9201 Sunset Boulevard, Suite 910 Los Angeles, CA 90069 Physician's and Surgeon's Certificate No. A30278, Respondent.	Case No. 17-1995-57676 OAH No. L-1999020077 **STIPULATED SETTLEMENT AND DECISION**

In the interest of a prompt and speedy settlement of this matter, consistent with the public interest and the responsibility of the Division of Medical Quality ("Division"), Medical Board of California ("Board"), Department of Consumer Affairs, the parties hereby agree to the following Stipulated Settlement and Decision which will be submitted to the Division for its approval and adoption as the final disposition and resolution of First Amended and Supplemental Accusation No. 17-1995-57676. This Stipulated Settlement and Decision also

serves as the final disposition and resolution of all complaints filed with the Board, investigations in progress, and complaints which may hereafter be filed with the Board based on allegations similar to those contained in First Amended and Supplemental Accusation No. 17-1995-57676, covering conduct occurring through March 2, 2000, including but not limited to the conduct complained of in Board case numbers 17-1998-85179, 17-1999-101893, and 17-2000-106688.

PARTIES

1. Complainant Ron Joseph is the Executive Director of the Board who brought this action solely in his official capacity and is represented in this matter by Bill Lockyer, Attorney General of the State of California, by Adrian K. Panton, Deputy Attorney General.

2. Raja Kairalla Srour, M.D. ("respondent"), is represented in this matter by attorneys Frank Albino, whose address is PARKER, MILLIKEN, CLARK, O'HARA & SAMUELIAN, a Professional Corporation, 333 South Hope Street, 27th Floor, Los Angeles, California 90071-1488, and Peter R. Osinoff, whose address is BONNE, BRIDGES, MUELLER, O'KEEFE & NICHOLS, a Professional Corporation, 3699 Wilshire Boulevard, 10th Floor, Los Angeles, California 90010-2719.

3. On or about July 27, 1976, Physician's and Surgeon's Certificate No. A30278 was issued to respondent by the Board. At all times relevant herein that license has been valid.

JURISDICTION

4. Accusation No. 17-1995-57676 was filed before the

Board and duly served on respondent, together with all other statutorily required documents, on July 13, 1998. Respondent filed a Notice of Defense (contesting the Accusation) dated July 22, 1998. A First Amended and Supplemental Accusation, was filed and duly served on respondent on February 29, 2000.

ADVISEMENT AND WAIVERS

5. Respondent has fully and completely discussed with his counsel the nature of the charges alleged in the Accusation and the effects of this stipulation.

6. Respondent understands that the charges and allegations in the First Amended and Supplemental Accusation, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate. Respondent is fully aware of his legal rights and that, but for this stipulation, he would be entitled: 1) to a hearing on the charges and allegations in the First Amended and Supplemental Accusation; 2) to be represented by counsel, at his own expense, in all proceedings in this matter; 3) to confront and cross-examine the witnesses against him; 4) to present evidence on his own behalf and to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; 5) to reconsideration and appeal of an adverse decision; and 6) all other rights accorded pursuant to the California Administrative Procedure Act and other applicable laws.

7. With these rights in mind, respondent freely, voluntarily, knowingly and intelligently waives and gives up each and every right set forth above.

8. Complainant and respondent desire to resolve this matter without the expense and uncertainty of further proceedings. Respondent agrees that, at a hearing, complainant could establish a factual basis for one or more of the charges in the First Amended and Supplemental Accusation.

CONTINGENCY

9. This stipulation shall be subject to the approval of the Division. Respondent understands and agrees that Board enforcement staff and counsel for complainant may communicate directly with the Board regarding this stipulation and settlement, without notice to or participation by respondent or his counsel. If the Division fails to adopt this stipulation as its Order, the stipulation shall be of no force or effect, it shall be inadmissible in any legal action between the parties, and the Division shall not be disqualified from further action in this matter by virtue of its consideration of this stipulation.

10. In consideration of the foregoing stipulations, the parties agree that the Division shall, without further notice or formal proceeding, issue and enter the following Disciplinary Order:

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A30278 issued to respondent is revoked. However, the revocation is stayed and respondent is placed on probation for ten (10) years on the following terms and conditions:

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1. **NOTIFICATION OF DECISION** Within 15 days after the effective date of this decision the respondent shall provide the Division, or its designee, proof of service that respondent has served a true copy of this decision on the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to respondent or where respondent is employed to practice medicine and on the Chief Executive Officer at every insurance carrier where malpractice insurance coverage is extended to respondent.

2. **COMMUNITY SERVICE - FREE SERVICES** Within sixty (60) days of the effective date of this decision, respondent shall submit to the Division or its designee for its prior approval a community service program in which respondent shall provide free medical services on a regular basis to a community or charitable facility or agency for at least 200 hours for each 12-month period during the first 2 years (24 months) of probation. Respondent shall have completed a total of 400 hours of community service, as determined in the preceding sentence, by the completion of the second year of probation.

3. **ETHICS COURSE** Within sixty (60) days of the effective date of this decision, respondent shall enroll in a course in Ethics approved in advance by the Division or its designee, and shall successfully complete the course during the first year of probation.

4. **PACE PROGRAM** Within ninety (90) days of the effective date of this decision, respondent, at his own expense, shall enroll in the Physician Assessment and Clinical Education

Program at the University of California, San Diego (hereinafter "PACE Program"), and shall undergo assessment, clinical training and examination.

First, respondent shall undergo the comprehensive assessment program including the measurement of medical skills and knowledge, [the appraisal of physical health, and psychological testing].[1] Second, after assessment, the PACE Program Evaluation Committee will review all results and make a recommendation to the Division, or its designee, and respondent as to (a) what clinical training is required, if any, including scope and length, and (b) any other factors affecting the respondent's practice of medicine. Respondent agrees to comply with the recommendations of the PACE Program Evaluation Committee.

AKP 5/18/00 PW 5/19/00

Respondent shall submit to an examination on the contents and substance of the clinical training, if any, which is recommended as set forth above. The examination shall be designed and administered by the PACE Program faculty. Respondent shall not be deemed to have successfully completed the program unless he passes the examination and/or fulfills the requirements of the Evaluation Committee's recommendations. Respondent agrees that the determination of the PACE Program faculty as to whether he has passed the examination, and/or fulfilled the requirements of the Evaluation Committee's

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1. The bracketed phrase is a modification of the stipulation as originally signed and is initialed and dated to reflect the parties' agreement to the modification.

recommendations, shall be binding.

Respondent shall complete the PACE Program no later than six (6) months after his initial enrollment unless the Division or its designee agrees in writing to a later time for completion. Respondent further agrees that successful completion of the PACE Program, including the passing of the examination and/or fulfillment of the Evaluation Committee's recommendations, shall be evidenced by a Certification of Successful Completion which shall be forwarded to the Division by a PACE Program representative.

If respondent fails to successfully complete the PACE Program within the time limits set forth above, he shall be suspended from the practice of medicine. Failure to participate in, and successfully complete all phases of the PACE Program as set forth above, shall constitute a violation of probation.

5. **BILLING MONITOR** Within thirty (30) days of the effective date of this decision, respondent shall submit to the Division or its designee for its prior approval a plan of review in which respondent's billings for medical services rendered shall be reviewed and monitored by another physician in respondent's field of practice, who shall provide periodic reports to the Division or its designee.

If the billing monitor resigns or is no longer available, respondent shall, within fifteen (15) days, move to have a new monitor appointed, through nomination by respondent and approval by the Division or its designee.

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6. **OBEY ALL LAWS** Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California, and remain in full compliance with any court ordered criminal probation, payments and other orders.

7. **QUARTERLY REPORTS** Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Division, stating whether there has been compliance with all the conditions of probation.

8. **PROBATION SURVEILLANCE PROGRAM COMPLIANCE** Respondent shall comply with the Division's probation surveillance program. Respondent shall, at all times, keep the Division informed of his business and residence addresses which shall both serve as addresses of record. Changes of such addresses shall be immediately communicated in writing to the Division. Under no circumstances shall a post office box serve as an address of record.

Respondent shall also immediately inform the Division, in writing, of any travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) days.

9. **INTERVIEW WITH THE DIVISION, ITS DESIGNEE OR ITS DESIGNATED PHYSICIAN(S)** Respondent shall appear in person for interviews with the Division, its designee or its designated physician(s) upon request at various intervals and with reasonable notice.

10. **TOLLING FOR OUT-OF-STATE PRACTICE, RESIDENCE OR IN-STATE NON-PRACTICE** In the event respondent should leave California to reside or to practice outside the State or for any reason should

respondent stop practicing medicine in California, respondent shall notify the Division or its designee in writing within ten (10) days of the dates of departure and return or the dates of non-practice within California. Non-practice is defined as any period of time exceeding thirty (30) days in which respondent is not engaging in any activities defined in Sections 2051 and 2052 of the Business and Professions Code. All time spent in an intensive training program approved by the Division or its designee shall be considered as time spent in the practice of medicine. Periods of temporary or permanent residence or practice outside California or of non-practice within California, as defined in this condition, will not apply to the reduction of the probationary period.

11. **COMPLETION OF PROBATION** Upon successful completion of probation, respondent's certificate shall be fully restored.

12. **VIOLATION OF PROBATION** If respondent violates probation in any respect, the Division, after giving respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an accusation or petition to revoke probation is filed against respondent during probation, the Division shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

13. **COST RECOVERY** The respondent is hereby ordered to reimburse the Division the amount of $9,000 within one year from the effective date of this decision for its investigative and prosecution costs. Failure to reimburse the Division's cost of

investigation and prosecution within one year from the effective date of this decision shall constitute a violation of the probation order, unless the Division agrees in writing to payment by an installment plan because of financial hardship. The filing of bankruptcy by the respondent shall not relieve the respondent of his responsibility to reimburse the Division for its investigative and prosecution costs.

14. **PROBATION COSTS** Respondent shall pay the costs associated with probation monitoring each and every year of probation, which are currently set at $2,304, but may be adjusted on an annual basis. Such costs shall be payable to the Division of Medical Quality and delivered to the designated probation surveillance monitor at the beginning of each calendar year. Failure to pay costs within 30 days of the due date shall constitute a violation of probation.

15. **LICENSE SURRENDER** Following the effective date of this decision, if respondent ceases practicing due to retirement, health reasons or is otherwise unable to satisfy the terms and conditions of probation, respondent may voluntarily tender his certificate to the Board. The Division reserves the right to evaluate the respondent's request and to exercise its discretion whether to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the tendered license, respondent will not longer be subject to the terms and conditions of probation.

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ACCEPTANCE

I have carefully read the above Stipulated Settlement and Decision and have fully discussed the terms and conditions and other matters contained therein with my attorneys, Frank Albino and Peter R. Osinoff. I understand the effect this stipulation will have on my Physician's and Surgeon's Certificate and agree to be bound thereby. I enter into this Stipulated Settlement and Decision knowingly, voluntarily, freely and intelligently.

DATED: April 4, 2000.

Raja Kairalla Srour, M.D.
Respondent

I have read and fully discussed with respondent Raja Kairalla Srour, M.D., the terms and conditions and other matters contained in the above Stipulated Settlement and Decision and approve its form and content.

DATED: _____.

Frank Albino
Attorney for Respondent

DATED: April 4, 2000.

Peter R. Osinoff
Attorney for Respondent

ENDORSEMENT

The foregoing Stipulated Settlement and Decision is hereby respectfully submitted for consideration of the Division of Medical Quality, Medical Board of California, Department of Consumer Affairs.

DATED: April 7, 2000.

BILL LOCKYER, Attorney General
of the State of California

Adrian K. Panton

Adrian K. Panton
Deputy Attorney General

Attorneys for Complainant

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Attorneys for Complainant

BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation Against: **RAJA KAIRALLA SROUR, M.D.** 9201 Sunset Boulevard, Suite 910 Los Angeles, CA 90069 Physician's and Surgeon's Certificate No. A30278, Respondent.	Case No. 17-1995-57676 OAH No. L-1999020077 **FIRST AMENDED AND SUPPLEMENTAL ACCUSATION**

The Complainant alleges:

PARTIES

1. Ron Joseph ("Complainant") brings this First Amended and Supplemental Accusation solely in his official capacity as the Executive Director of the Medical Board of California (hereinafter the "Board"). This First Amended and Supplemental Accusation amends and supplements the Accusation previously filed in this action on July 13, 1998.

2. On or about July 27, 1976, Physician's and Surgeon's Certificate No. A30278 was issued by the Board to Raja Kairalla

Srour, M.D. (hereinafter "respondent"). At all times relevant to the charges brought herein, this license has been in full force and effect. Unless renewed, it will expire on March 31, 2001.

JURISDICTION

3. This accusation is brought before the Division of Medical Quality of the Medical Board of California, Department of Consumer Affairs (hereinafter the "Division"), under the authority of the following sections of the Business and Professions Code (hereinafter "Code"):

A. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Division deems proper.

B. Section 2234 of the Code provides that unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provision of this chapter.

"(b) Gross negligence.

"(c) Repeated negligent acts.

"(d) Incompetence.

"(e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and

surgeon.

"(f) Any action or conduct which would have warranted the denial of a certificate."

C. Section 810 of the Code states:

"(a) It shall constitute unprofessional conduct and grounds for disciplinary action, including suspension or revocation of a license or certificate, for a health care professional to do any of the following in connection with his or her professional activities:

"(1) Knowingly present or cause to be presented any false or fraudulent claim for the payment of a loss under a contract of insurance.

"(2) Knowingly prepare, make, or subscribe any writing, with intent to present or use the same, or to allow it to be presented or used in support of any false or fraudulent claim.

"(b) It shall constitute cause for revocation or suspension of a license or certificate for a health care professional to engage in any conduct prohibited under Section 1871.4 of the Insurance Code or Section 550 of the Penal Code.

"(c) As used in this section, health care professional means any person licensed or certified pursuant to this division, or licensed pursuant to the Osteopathic Initiative Act, or the Chiropractic Initiative Act."

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E. Code section 2261 provides:

"Knowingly making or signing any certificate or other document directly or indirectly related to the practice of medicine or podiatry which falsely represents the existence or nonexistence of a state of facts, constitutes unprofessional conduct."

F. Code section 2262 provides:

"Altering or modifying the medical record of any person, with fraudulent intent, or creating any false medical record, with fraudulent intent, constitutes unprofessional conduct.

"In addition to any other disciplinary action, the Division of Medical Quality or the California Board of Podiatric Medicine may impose a civil penalty of five hundred dollars ($500) for a violation of this section."

G. Code section 732 provides:

"(a) A physician and surgeon and a dentist shall refund any amount that a patient has paid for services rendered that has subsequently been paid to the physician and surgeon or dentist by a third-party payor and that constitutes a duplicate payment. The refund shall be made as follows:

"(1) If the patient requests a refund, within 30 days following the request from that patient for a refund if the duplicate payment has been received, or within 30 days of receipt of the duplicate payment if the duplicate payment has not been received.

"(2) If the patient does not request a refund, within 90 days of the date the physician and surgeon or dentist knows,

or should have known, of the receipt of the duplicate payment, the physician and surgeon or dentist shall notify the patient of the duplicate payment, and the duplicate payment shall be refunded within 30 days unless the patient requests that a credit balance be retained.

"(b) Violation of this section shall constitute unprofessional conduct. Disciplinary proceedings shall be conducted in accordance with the Medical Practice Act (Chapter 5 (commencing with section 2000)) or the Dental Practice Act (Chapter 4 (commencing with section 1600)), as applicable."

H. Section 125.3 provides, in part, that the Board may request the administrative law judge to direct any licentiate found to have committed a violation or violations of the licensing act, to pay the Board a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

PROHIBITION AGAINST MEDI-CAL REIMBURSEMENT

I. Section 14124.12 of the Welfare and Institutions Code in relevant part provides:

"(a) Upon receipt of written notice from the Medical Board of California . . . that a licensee's license has been placed on probation as a result of a disciplinary action, the department [State Department of Social Services] may not reimburse any Medi-Cal claim for the type of surgical service or invasive procedure that gave rise to the probation, including any dental surgery or invasive procedure, that was performed by the licensee on or after the effective date of

probation and until the termination of all probationary terms and conditions or until the probationary period has ended, whichever occurs first. This section shall apply except in any case in which the relevant licensing board determines that compelling circumstances warrant the continued reimbursement during the probationary period of any Medi-Cal claim, including any claim for dental services, as so described. In such a case, the department shall continue to reimburse the licensee for all procedures, except for those invasive or surgical procedures for which the licensee was placed on probation.

"* * * * * *"

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

4. Respondent Raja Kairalla Srour, M.D. is subject to disciplinary action for gross negligence under subdivision (b) of Code section 2234 in that with respect to patients R.A.,[1/] M.K., C.D., and S.M. he (1) prepared false medical records, (2) prepared false operative reports, and (3) submitted insurance billings for procedure not performed, (4) double billed for services performed, and (5) failed to provide adequate preoperative and intra-operative care to patients M.K. and C.D. and postoperative care to patient S.M. The circumstances are as follows:

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1. To ensure privacy, the patients will be referred to by initials. The full name of the patient, who is known to respondent, will be disclosed to respondent in this proceeding when discovery is provided in compliance with Government Code section 11507.6.

Patient R.A.

A. On or about December 3, 1990, R.A. went to respondent, a plastic surgeon, for advice on cosmetic surgery to correct a nasal deformity. Respondent advised nasal reconstruction which was further discussed with R.A. in an office visit on March 1, 1991.

B. Although R.A. provided no such information, respondent documented in his December 3 office notes that R.A. had breathing difficulties, especially through his right nostril, and had recent trauma to the nose. In a letter dated February 20, 1991, respondent wrote to R.A.'s insurance carrier that R.A. had breathing difficulties following blunt trauma to the nose inflicted a month prior to the visit. The letter indicated R.A. visited respondent on February 20 but respondent's office records do not show any such visit.

C. The surgery was performed on March 8, 1991. An operative consent dated March 7, 1991 for SMR Rhinoplasty was signed by R.A. A sheet labeled "Rhinoplasty: Possible Risks" and dated March 8, was signed by R.A. and witnessed. Respondent did not discuss with R.A., nor did the signed "risk" sheet mention the risk of death, risk of blood transfusion, septal perforation, failure to correct the deformity or lack of consortium due to complications from the operation.

D. The operative report prepared by respondent documented that the cartilaginous septum of the nose was excised. Portions of the vomer and ethmoid (bones of the nasal cavity) were then rongeured (filed down) to give adequate nasal passage. The middle turbinates were also rongeured. Cartilage and mucosa were excised from the distant end of the septum. The nasal hump was then rasped and both nasal bones were fractured to correct the deformity. Respondent admitted that the operative report described procedures which he did not perform including the removal of cartilage.

E. Following the March 8 surgery, R.A. experienced complications which required additional surgery to stem excessive bleeding. This corrective surgery was performed on March 13, 1991. In the operative report for the March 13 surgery, respondent documented that he performed the surgery when in fact it was performed by another surgeon.

F. Respondent submitted a billing to R.A.'s insurance carrier for the following surgical procedures: (1) correction of deformity; (2) major septoplasty [correction of the septum]; (3) radical submucous resection of septum; (4) bilateral vomerectomy; (5) ethmoid plate resection; and (6) submucous resection of turbinates.

G. By his own admission, respondent failed to perform several of the procedures for which he billed

R.A.'s carrier including the bilateral vomerectomy (subpar. E(4)) which is physically impossible since there is only one vomer bone.

H. Respondent was grossly negligent for individually and collectively (1) preparing a false record documenting the medical condition of patient R.A., (2) preparing false operative reports, and (3) submitting insurance billings for procedures not performed.

Patient M.K.

I. According to records maintained by respondent, patient M.K., a female age 33, presented to him for the first time on November 1, 1995, for consultation for face and eyelid wrinkles. The next entry reflects a visit on October 1, 1996, when M.K. consulted with respondent for breast enlargement and liposuction to her upper legs. As reflected in the records respondent provided to the Board for investigation of the case, surgery was performed on November 27 at the Doheny Surgical Center. In the November 27 operative report, the preoperative diagnosis was stated as: "Atrophy and ptosis [drooping] of breasts. Mastodynia [pain in the breast]. Inframammary intertrigo [superficial inflammation of breast skin] - Fat deposits in thighs and knees." The operation summary segment of the report and respondent's office notes stated: "Excision inframammary bands. Bilateral breast augmentation. Liposuction of thighs and knees." M.K. underwent the surgery as stated in the report respondent

provided to the Board.

J. The report respondent submitted to M.K.'s health insurance carrier and third party administrator in support of his claim for payment, indicated the date of surgery as November 26 instead of November 27 as reflected in the records respondent provided to the Board. In this report, respondent stated in the preoperative diagnosis: "Bilateral breast hypertrophy; back pain; inframmary intertrigo; pain in shoulders." The operation performed was summarized as: "Bilateral subtotal mastectomies, with recontrucion [sic]." This report was not the same report which respondent provided to the Board as reflective of the November 26/27 surgical procedure.

K. Prior to the November 26/27 surgery, respondent photographed the breasts and thighs of M.K. M.K. identified and affirmed that the photographs respondent provided to the Board for its investigation of the case were those taken of her by respondent prior to the surgery. In support of his claim for payment to M.K.'s health insurance carrier, respondent submitted a photograph of the breasts of a person who was not M.K.

L. Respondent informed M.K. that the cost for the breast augmentation and liposuction was $5,000 which she paid respondent by check and credit card prior to the surgery. Unknown to M.K., respondent also billed her health insurance carrier $11,475 for the October 1 consultation and examination and the November 26/27 surgery. After receipt of the $5,000

from M.K., respondent was reimbursed in excess of $7,800 by M.K.'s health insurance carrier for the services he provided on October and November 26/27. Respondent did not offer or refund to M.K. any of the $5,000 she paid to him.

M. Respondent admitted that he did not routinely maintain records of a preoperative physical and history nor of postopertive monitoring of the patient as required by the community standard of practice. Respondent also did not perform a preoperative history and physical examination on M.K. even though the community standard of care requires such when, as in the case of M.K., the surgical procedure was performed under general anesthesia.

N. Respondent was grossly negligent based on the following acts and omissions, both individually and collectively, as follows: (1) respondent prepared false medical records for M.K.; (2) respondent billed both M.K. and her health insurance carrier for the same surgery performed on November 26/27; (3) respondent committed insurance fraud; (4) respondent failed to perform a preoperative physical and history for M.K.; (5) respondent did not adequately document his postoperative monitoring of M.K.; and (6) respondent performed surgery on M.K. when the only other person present was his front office assistant who was neither a licensed nurse nor a certified surgical technician.

Patient C.D.

O. According to records maintained by respondent, patient C.D., a female age 24, presented to him for the first

time on or about February 7, 1997, for consultation for cosmetic breast surgery. C.D. denies that she saw respondent on February 7, 1997 or any date prior to January 8, 1998. The next record entry reflects a visit on January 8, 1998, when surgery was again discussed. Surgery was performed on January 23 at the Doheny Surgical Center. In the January 23 operative report respondent provided to the Board for its investigation of the case, the preoperative diagnosis was stated as: "Assymetry of Breasts. Semi-tuberous right breast. Ptosis left breast." Respondent's medical record notes for C.D. indicated the following surgical procedures for January 23: "Excision band right imframammary [sic] area. Breast augmentation. Left breast lift and excision of fatty tissue. Breast augmentation." C.D. acknowledged that the January 23 surgery involved implants in both breasts and a breast lift in one of her breasts.

P. In the report respondent submitted to C.D.'s health insurance carrier and third party administrator in support of his claim for payment, he stated in the preoperative diagnosis: "Bilateral breast hypertrophy; back pain; inframammary intertrigo; pain in shoulders." The operation performed was summarized as: "Bilateral subtotal mastectomies, with recontrucion [sic]." This report was not the same report which respondent provided to the Board as reflective of the January 23 surgical procedure.

Q. Prior and subsequent to the January 23 surgery, respondent photographed the breasts of C.D. C.D. identified

and affirmed that the photographs respondent provided to the Board for its investigation of the case were those taken of her by respondent prior and subsequent to the surgery. In support of his claim for payment to C.D.'s health insurance carrier, respondent submitted photographs of the breasts of a person who was not C.D.

R. Respondent informed C.D. that the cost for the breast augmentation and liposuction was $5,000 which she paid respondent by cashier's check and personal check. Unknown to C.D., respondent also billed her health insurance carrier $11,525 for the January 8 consultation and examination and the January 23 surgery. After receipt of the $5,000 from C.D., respondent was paid $8,000 by C.D.'s health insurance carrier for the services he provided on January 8 and 23. By written agreement signed by respondent, respondent agreed that he would not bill or seek payment from C.D. for the difference between the billed charges and the payment provided by the insurance carrier. Respondent did not offer or refund to C.D. any of the $5,000 she paid to him.

S. Respondent admitted that he did not routinely maintain records of a preoperative physical and history nor of postopertive monitoring of the patient as required by the community standard of practice. Respondent also did not perform a preoperative history and physical examination on C.D. even though the community standard of care requires such when, as in the case of C.D., the surgical procedure was performed under intravenous sedation. The community standard

of care requires the presence in the operating room of at least a licensed nurse or a certified surgical technician in addition to the surgeon. Respondent admitted that the only person present during the surgery was his front office assistant who was neither a licensed nurse nor a certified surgical technician.

T. Respondent was grossly negligent based on the following acts and omissions, both individually and collectively, as follows: (1) respondent prepared false medical records for C.D.; (2) respondent billed both C.D. and her health insurance carrier for the same surgery performed on January 23; (3) respondent committed insurance fraud; (4) respondent failed to perform a preoperative physical and history for C.D.; (5) respondent did not adequately document his postoperative monitoring of C.D; and (6) respondent performed surgery on C.D. when the only other person present was his front office assistant who was neither a licensed nurse nor a certified surgical technician.

Patient S.M.

U. On or about December 18, 1998, patient S.M., a female age 38, presented to respondent for consultation for breast augmentation. The surgery was performed on March 19, 1999, at the Doheny Surgical Center. In the March 19 operative report included in the medical records for S.M. which respondent provided to the Board for its investigation of the case, the preoperative diagnosis was stated as: "Ptosis of breasts, constricting band in inframammary fold."

The operation summary segment of the report stated: "Bilateral breast augmentation, bilateral excision of constricting inframammary bands." Respondent's office notes also described the surgery performed as: "Excision bilateral inframammary bands, Bilateral breast augmentation." S.M. underwent the surgery as stated in the operative report respondent provided to the Board.

V. The report respondent submitted to S.M.'s health insurance carrier and third party administrator in support of his claim for payment indicated the date of surgery as January 27, 1999, instead of March 19, 1999, as stated in the records respondent provided to the Board. Respondent acknowledged, however, that the surgery occurred on March 19. In the January 27 operative report, respondent stated in the preoperative diagnosis segment: "Bilateral breast hypertrophy; back pain; inframammary intertrigo; pain in shoulders." The operation performed was summarized as: "Bilateral subtotal mastectomies, with recontrucion [sic]." This report was not the same report which respondent provided to the Board as reflective of the March 19 surgical procedure.

W. As reported by S.M., following the March 19 surgery, she had follow-up visits with respondent on March 22 and March 26. On the March 26 visit, S.M. complained to respondent about swelling and pain in her left breast. Respondent told her there was nothing to worry about. The discomfort in S.M.'s left breast continued and on her next follow-up visit on April 8, she complained that the breast was

red and hot. Respondent documented the redness in the breast and prescribed Keflex and noted that there was an absence of fever and tenderness. S.M. was next seen by respondent on April 16 and although he documented a redness on the right breast, told S.M. that she did not have an infection. In his notes for April 16, respondent documented that there was no tenderness and no cellulitis (an infection). On April 23, S.M. called respondent to report that another physician told her that she had cellulitis and would require hospitalization for treatment by intravenous antibiotics. On May 14, respondent underwent surgery at Martin Luther Hospital in Anaheim for removal of both implants which respondent implanted on March 19. The preoperative and postoperative diagnosis for the May 14 surgery, was bilateral breast cellutitis. The infection was so serious that S.M. was hospitalized for two days following the May 14 surgery. When respondent was interviewed by the Board investigative staff on October 26, 1999, he denied that S.M. had a postoperative infection.

X. Respondent billed S.M.'s health care insurance carrier $11,550 for the surgery described in the January 27 report plus $11,829 for the Doheny Surgical Center. Included in the billing for the surgery was an entry for service provided on January 4, 1999. In the records respondent provided to the Board, there is no entry showing that a service was provided on January 4. Prior to the March 19 surgery, respondent photographed the breasts of S.M. S.M.

identified and affirmed that the photographs respondent provided to the Board for its investigation of the case were those taken of her by respondent prior to the surgery. In support of his claim for payment to S.M.'s health insurance carrier, respondent submitted a photograph of the breasts of a person who was not S.M.

Y. Respondent was grossly negligent based on the following acts and omissions, both individually and collectively, as follows: (1) respondent failed to diagnose and treat a significant postoperative infection sustained by S.M.; and (2) respondent committed insurance fraud by billing S.M.'s health insurance carrier for a procedure he did not perform and fabricating an operative report.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

5. Respondent is subject to disciplinary action for repeated negligent acts involving patient R.A. under subdivision (c) of Code section 2234. The circumstances are as follows:

A. The facts and allegations in paragraph 4, subparagraphs A through H, inclusive, are incorporated here by reference.

THIRD CAUSE FOR DISCIPLINE

(Incompetence)

6. Respondent is subject to disciplinary action for incompetence under subdivision (d) of Code section 2234. The circumstances are as follows:

A. The facts and allegations in paragraph 4,

subparagraphs A through Y, inclusive, are incorporated here by reference

FOURTH CAUSE FOR DISCIPLINE

(Presentation of False Claims for Payment of Insurance Proceeds)

7. Respondent is subject to disciplinary action under Code section 810, subdivision (a)(1), in that he knowingly presented false claims for the payment of insurance proceeds. The circumstances are as follows:

A. The facts and allegations in paragraph 4, subparagraphs A through Y, inclusive, are incorporated here by reference.

FIFTH CAUSE FOR DISCIPLINE

(False Entries In Medical Record)

8. Respondent is subject to disciplinary action under Code section 2261 for making false entries in the medical record of patients. The circumstances are as follows:

A. The facts and allegations in paragraph 4, subparagraphs A through Y, inclusive, are incorporated here by reference.

SIXTH CAUSE FOR DISCIPLINE

(Creating A False Medical Record)

9. Respondent is subject to disciplinary action under Code section 2262 for creating a false medical record for patients.. The circumstances are as follows:

A. The facts and allegations in paragraph 4, subparagraphs A through Y, inclusive, are incorporated here by reference.

SEVENTH CAUSE FOR DISCIPLINE

(Refund of Overpayments)

10. Respondent is subject to disciplinary action under Code section 732 for failing to refund overpayments. The circumstances are as follows:

A. The facts and allegations in paragraph 4, subparagraphs A through T, inclusive, are incorporated here by reference.

EIGHTH CAUSE FOR DISCIPLINE

(Dishonesty)

11. Respondent is subject to disciplinary action under subdivision (e) of Code section 2234 for dishonesty. The circumstances are as follows:

A. The facts and allegations in paragraph 4, subparagraphs A through Y, inclusive, are incorporated here by reference.

NINTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

12. Respondent is subject to disciplinary action under Code section 2234 for unprofessional conduct. The circumstances are as follows:

A. The facts and allegations in paragraph 4, subparagraphs A through Y, inclusive, are incorporated here by reference.

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PRAYER

WHEREFORE, the complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Division issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number A30278, heretofore issued to respondent Raja Kairalla Srour, M.D.;

2. Revoking, suspending or denying approval of respondent's authority to supervise physician's assistants, pursuant to section 3527 of the Code;

3. Ordering respondent to pay the Division the reasonable costs of the investigation and enforcement of this case and, if placed on probation, the costs of probation monitoring;

4. Ordering respondent to pay the Division a civil penalty of $500 under Code section 2262;

5. Taking such other and further action as the Division deems necessary and proper.

DATED: February 28, 2006.

Ron Joseph by AKP(DAG)
Ron Joseph
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California

Complainant